REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY PART - C (Revised)

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL

a. Name of TPA / Insurance company: VIDAL HEALTH INSURANCE TPA PRIVATE LTD. / UNITED INDIA

b. Toll free phone number:

c. Toll free fax:

d. Name of Hospital: Z CLINIX ADVANCED EYE CARE

i. Address 27/11 VIKRAM VIHAR, LAJPAT NAGAR

ii. Rohini id

iii. e-mail id

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient : DILIP KUMAR SHARMA

B. Gender: ☑ Male ☐ Female ☐ Third Gender

C. Age: 34 (Years) / (Month)

D. Date of Birth: 8-7-1988 (DD/MM/YYYY)

E. Contact number: 9953869484

F. Contact number of attending Relative:

G. Insured Card ID number:

H. Policy number / Name of Corporate: 040200 2822P101982910

I. Employee ID:

J. Currently do you have any other mediclaim / health insurance: ☐ Yes ☑ No

i. Company Name:

ii. Give Details - N/A -

K. Do you have a family Physician: ☐ Yes ☑ No

L. Name of the Family Physician:

M. Contact number, if any:

N. Current Address of Insured patient: - N/A -

O. Occupation of Insured patient:

(PLEASE COMPLETE DECLARATION OF THIS FORM)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A. Name of the treating Doctor: DR VARUN GOYAL

B. Contact number: 9911392440

C. Nature of Illness / Disease with presenting complaint: BOTH B/E

D. Relevant Critical Findings: B/E REFRECTIVE ERROR

E. Duration of the present ailment: _____ Days

i. Date of First consultation: _____ (DD/MM/YYYY)

ii. Past history of present ailment, if any _____

F. Provisional diagnosis: B/E REFRACTIVE ERROR

i. ICD 10 code _____

G. Proposed line of treatment:

i. Medical Management ( )
ii. Surgical Management (✓)
ii. Intensive care ( )
iv. Investigation ( )
v. Non-allopathic treatment ( )

H. If investigation and / or Medical Management, provide details _____

i. Route of Drug Administration : _____

I. If surgical, name of surgery B/E LASIK SURGERY

i. ICD I0 PCS code _____

J. If other treatment, provide details - N/A -

K. How did injury occur _____

L. In case of accident

i. Is it RTA: ☐ Yes ☐ ~~No~~
ii. Date of Injury: _____ (DD/MM/YYYY)
iii. Report to Police ☐ Yes ☐ ~~No~~
iv. FIR NO: _____
v. Injury / Disease caused due to substance abuse / alcohol consumption ☐ Yes ☐ ~~No~~
vi. Test conducted to establish this (if yes, attach report) ☐ Yes ☐ ~~No~~

M. In case of Maternity ☐ G ☐ P / ☐ L ☐ A

i. expected date of Delivery _____ (DD/MM/YYYY)

DETAILS OF PATIENT ADMITTED

A. Date of admission — 7-6-23 (DD/MM/YYYY)

B. Time of admission — 11:00 (HH:MM)

C. Is this an emergency / planned hospitalization event: Emergency ☐ Planned ☑

D. Mandatory Past History of any chronic illness — if yes (since __/____)(month/year)

i. Diabetes
ii. Heart disease
iii. Hypertension
iv. Hyperlipidemias
v. Osteoarthritis
vi. Asthma/COPD/Bronchitis
vii. Cancer
viii. Alcohol/Drug abuse
iX. Any HIV/ or STD Related ailment
X. Any other ailment, give details

E. Expected number of Days / stay in hospital — 01 Days

F. Days in ICU — Days

G. Room Type — DAY CARE

H. Per day room rent+nursing and service charges+ patients diet

I. Expected cost of investigation + diagnostic

J. ICU charges

K. OT charges

L. Professional fees Surgeon + Anesthetist Fees + consultation Charges

M. Medicines + Consumables + Cost of Implants (if applicable please specify)

N. Other hospital expenses if any — As Per (SOC) PKG

O. All-inclusive package charges if any applicable

P. Sum Total expected cost of hospitalization — 85000/-

DECLARATION
(Please read very carefully)

We confirm having read understood and agreed to the Declarations of this form

a. Name of the treating doctor

b. Qualification:

c. Registration number with State code

CLINIC - Advanced Eye Care Lajpat Nagar-IV N.D.-24

Hospital Seal
(Must include Hospital ID)

Patient / Insured Name and Sign

UNITED INDIA INSURANCE COMPANY LIMITED

30-31 A, JEEVAN VIKAS BUILDING ASAF ALI ROAD NEW DELHI, NEW DELHI, DELHI
CENTRAL DELHI 110002 DELHI
PH: (011) 23232443 FAX: EMAIL:

FAMILY MEDICARE POLICY
UIN. UIIHLIP22070V042122
POLICY NO.: 0402002822P101982910

PERIOD OF INSURANCE
FROM 00:00 Hrs on 02/06/2022
To MIDNIGHT on 01/06/2023

Insured
M/s TALBROS AUTOMOTIVE COMPONENTS LTD..
14/1 MATHURA ROAD FARIDABAD HARYANA

121002
FARIDABAD
HARYANA

Agent Name	: **ZOOM INSURANCE BROKERS PVT LTD**
Agent Code	: **BRC0000699**
Mobile/Landline Number/Email	: **9999971793** shashi.shekhar@zoominsurancebrokers.com

The genuineness of the policy can be verified through "Verify Your Policy" link at www.uiic.co.in.

For any Information, Service Requests and Grievances please write to 040200@uiic.co.in

For ID Cards & Claim Intimations Please contact the TPA mentioned in the Policy document.

FAMILY MEDICARE POLICY

Policy Number	0402002822P101982910			Previous Policy No.	0402002821P104597247
Insured Detail	Name/ID	M/s TALBROS AUTOMOTIVE COMPONENTS LTD.. /23042189198			
	Tel.(O)		Tel.(R)	Fax	
	EMail	sanjib.gupta@zoominsurancebrokers.com		Mobile	9971069442
	Business/Occupation	None			
Period Of Insurance	From	00:00hrs of 02/06/2022	To	Midnight on 01/06/2023	
Policy Type	Family Floater Basis	Family Floater SI(₹)	200,000.00		

Coinsurance	UIIC 040200 : 100%

Insured Details

Sl no	Insured Name	Date of Birth	Gender	Relation	Occupation	Pre-Existing Disease /Condition declared	Inception Date of first policy	Nominee Name	Nominee Relation	Base Cover Premium(₹)
1	DILIP KUMAR SHARMA	18/07/1988	Male	Self	Salaried	None	02/06/2014	RANJEETA	Spouse	8,091.00
2	RANJEETA SHARMA	31/07/1990	Female	Spouse	Unemployed	None	02/06/2014	DILIP KUMAR SHARMA	Spouse	
3	NIDHI SHARMA	17/04/2011	Female	Daughter	Unemployed	None	02/06/2014	DILIP KUMAR SHARMA	Father	

Optional Cover & Premium Details

Hospital Daily Cash Limit (Per Day)(₹)	Not Opted	**Hospital Daily Cash Limit (Per Policy)(₹)**	Not Opted
Restore SI Opted	No	**Pre-Existing Disease/ condition loading**	No
Maternity & New Born Baby Cover Opted		No	

Total Basic Premium(₹)	8,091.00
Add Hospital Daily Cash Premium(₹)	0.00
Add Maternity Expenses/ New Born Baby Cover Premium(₹)	0.00
Add Restoration of SI Premium(₹)	0.00
Add PED Loading(₹)	0.00
Less Family Discount(₹)	0.00
Less No Claim Discount(₹)	1,213.65
Less Online Discount(₹)	0.00

Premium:	₹	6,877.00
IGST(18%)	₹	1,238.00
Stamp Duty:	₹	1.00
Total:	₹	8,115.00
Receipt Number :		1010402002210225074 1
Receipt Date:		03/06/2022

Agent Name	ZOOM INSURANCE BROKERS PVT LTD	Agent/Broker Code	BRC0000699
Development Officer Name		Development Officer Code	

Customer GST/UIN No.:	06AAACT0265F1ZQ	**Office GST No.:**	07AAACU5552C1ZL
SAC Code:	997133	**Invoice No. & Date:**	28221101982910 & 03/06/2022
Amount Subject to Reverse Charges-NIL			

Anti Money Laundering Clause:-In the event of a claim under the policy exceeding ₹ 1 lakh or a claim for refund of premium exceeding ₹ 1 lakh, the insured will comply with the provisions of AML policy of the company. The AML policy is available in all our operating offices as well as Company's web site.

LET US JOIN THE FIGHT AGAINST CORRUPTION. PLEASE TAKE THE PLEDGE AT https://pledge.cvc.nic.in.

Date of Proposal and Declaration: 02/06/2022
IN WITNESS WHEREOF, the undersigned being duly authorised has hereunto set his/her hand at DO 2 NEW DELHI 040200 on this 01st day of June ,2022.

For and On behalf of
United India Insurance Co. Ltd.

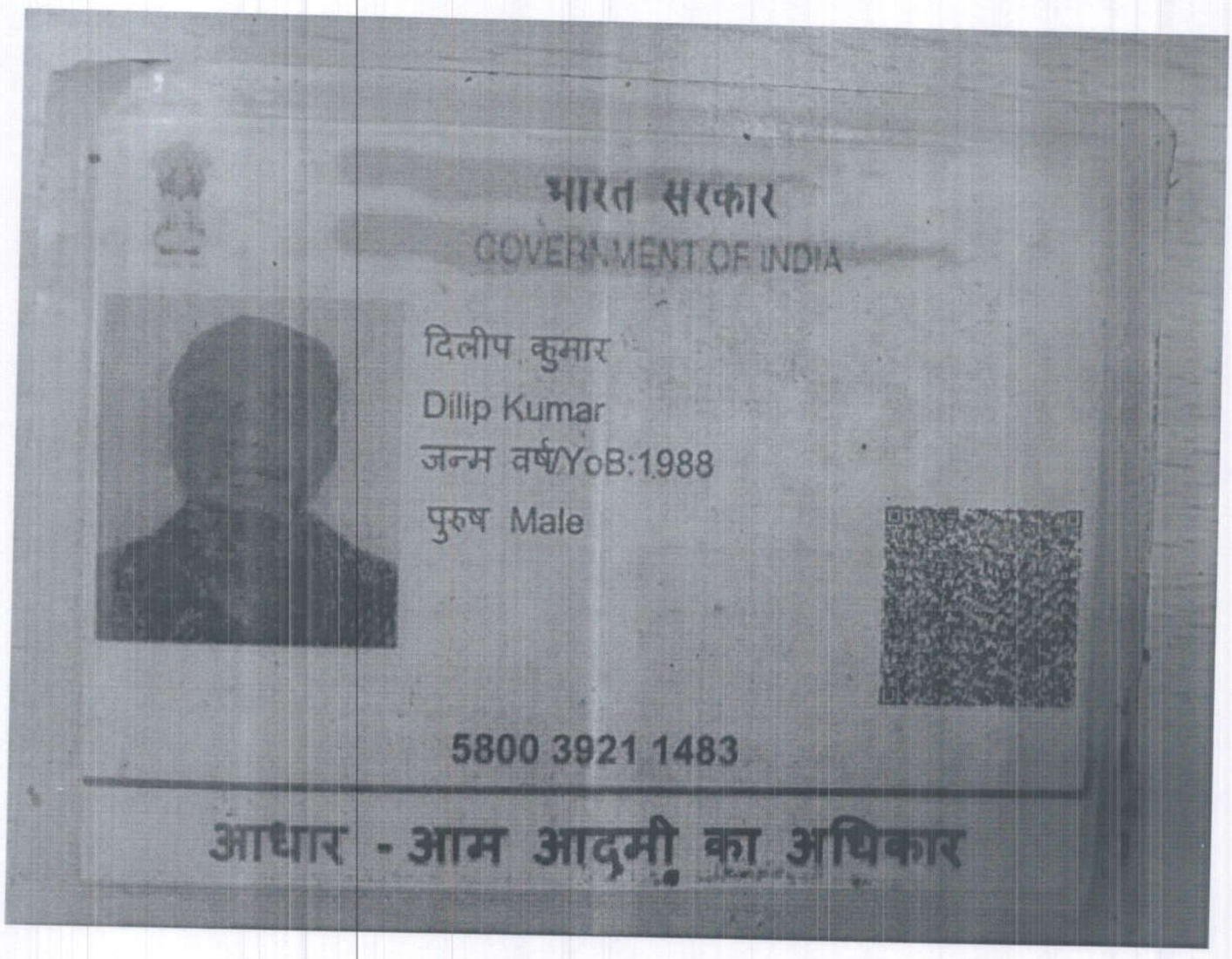
Affix Policy Stamp Here

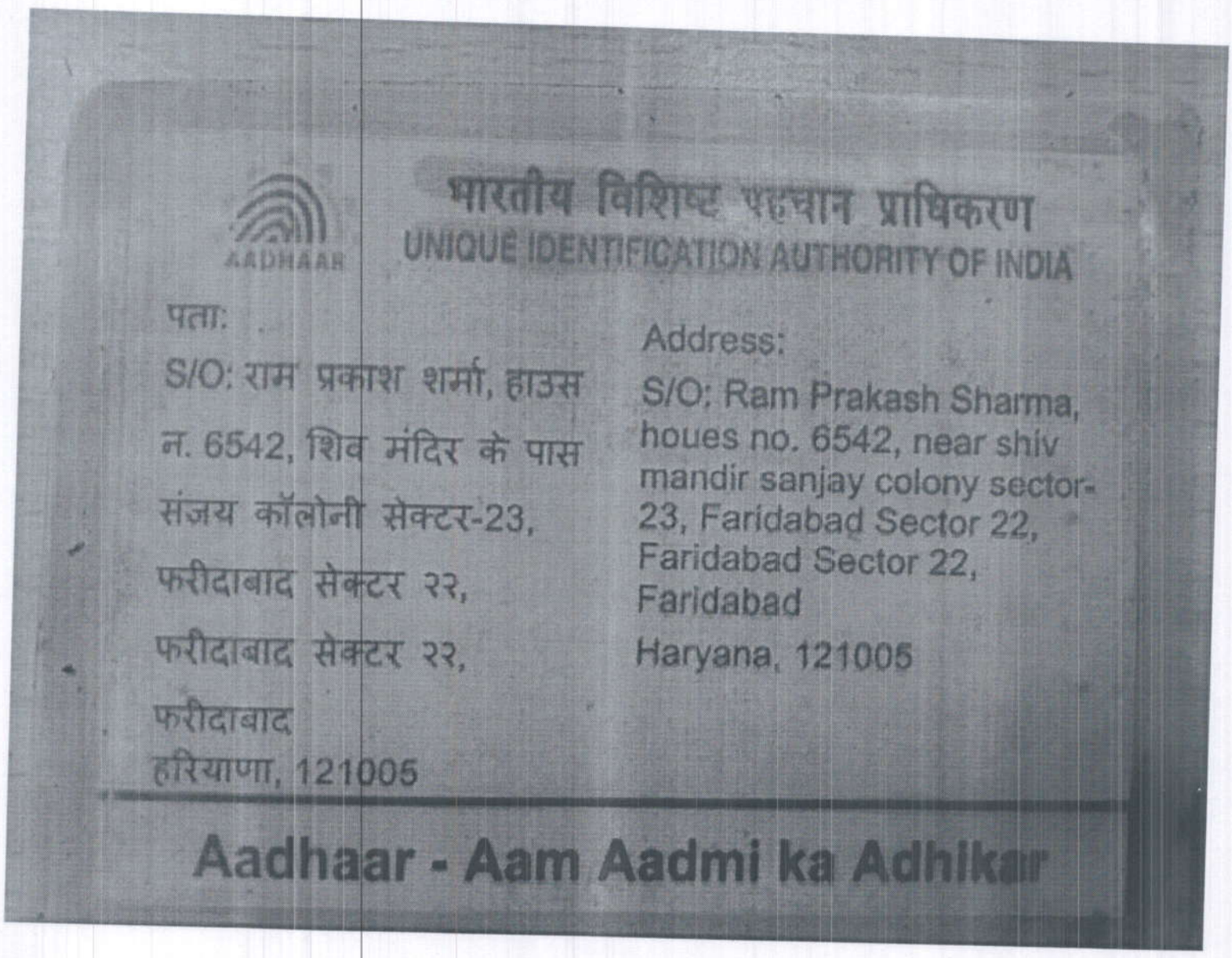
Authorised Signatory.

Underwritten By - PAR46120 (DO UW CUM CASHIER)

Details of TPA:
Please contact the following TPA for Issue of Identity Cards, Cashless Approvals & Claims Settlement.

Name of TPA/ID	VIDAL HEALTH TPA PRIVATE LTD / TPA00019			
Address	SJR I Park | Plot No :13,14,15, Tower 2,Tower 2, 1st floor, SJR I Park,Plot No; 13,14,15, EPIP Area, Whitefield, Bangalore - 560066, Pin Code : 560066, Fax No :			
Toll Free number	18604250251/080-46267018			
Contact Details	**For General Enquiries**	**For Cashless approval**	**For Claim intimation**	**For Grievances**
Telephone Numbers	18604250251/080-46267018	18604250251/080-46267018	18604250251/080-46267018	18604250251/080-46267018
Email IDs	help@vidalhealthtpa.com	help@vidalhealthtpa.com	Intimation@vidalhealthtpa.com	greivances@vidalhealthtpa.com


भारत सरकार
GOVERNMENT OF INDIA
दिलीप कुमार
Dilip Kumar
जन्म वर्ष/YoB:1988
पुरुष Male
5800 3921 1483
आधार - आम आदमी का अधिकार


AADHAAR
भारतीय विशिष्ट पहचान प्राधिकरण
UNIQUE IDENTIFICATION AUTHORITY OF INDIA
पता:
S/O: राम प्रकाश शर्मा, हाउस न. 6542, शिव मंदिर के पास संजय कॉलोनी सेक्टर-23, फरीदाबाद सेक्टर २२, फरीदाबाद सेक्टर २२, फरीदाबाद हरियाणा, 121005
Address:
S/O: Ram Prakash Sharma, houes no. 6542, near shiv mandir sanjay colony sector-23, Faridabad Sector 22, Faridabad Sector 22, Faridabad Haryana, 121005
Aadhaar - Aam Aadmi ka Adhikar

Mark of Excellence

E-mail : iclinix@gmail.com

iCLINIX
Advanced Eye Care
"Expert Care by AIIMS Alumni"
Centre for Retina & Lasers

QCI Accredited

Dr. Varun Gogia
MBBS (AIIMS), MD (AIIMS)
Senior Registrar (AIIMS)
Clinical Observer, Cleveland Clinic, USA
Honorary Visiting Consultant : Asan Eye Clinic, Dushanbe, Tajikistan
Senior Consultant Ophthalmology, Fortis C-DOC

Patient ID	16246	Visit Date/Time	02/Jun/2023 03:16 PM
Patient Name	Mr. Dilip Kumar	Age/Sex	34 Yrs / M
Patient Address	H No - 6542 Sanjay Colony Sec - 33 Faridabad	Contact No.	9953869484
Category	General	Old MR No.	

Present Complaints

Blurring Of Vision.

OPD Test & Examination

Test Name	Right Eye	Left Eye
CCT	556	558
Epithelial Thickness	56	57
ColorVision Ishihara s Tests	Normal	Normal
Schirmer Test	5	5

Vision	Distance Vision		Near Vision	
	Right Eye	Left Eye	Right Eye	Left Eye
Unaided	CF@2M	CF@2M		
Best Correct	6/6	6/6	N6	N6

Method Name	IOP Time	Right Eye	Left Eye
NCT	02:03	16	18

Adv.Glasses	Right Eye						Left Eye					
	Sph	Cyl	Axis	Prism	V/A	N/V	Sph	Cyl	Axis	Prism	V/A	N/V
Distance	-8.00	-0.50	40		6/6	N6	-8.25	-0.50	50		6/6	N6

Diagnosis Comments/Clinical Impression :

Both eyes refractive error

Doctor's Advice :

plan for BE LASIK SX

NEXT REVIEW : AS AND WHEN REQUIRED

Dr. Varun Gogia
MBBS(AIIMS), MD(AIIMS)
Director
DMC Reg:- R04624

Dr.Varun Gogia

MBBS(AIIMS), MD(AIIMS)

PPN NETWORK - DECLARATION BY PATIENT/PATIENT'S ATTENDANT

Name of the Hospital **I Clinix Advanced Eye Care** Date :... 6/6/23

Address : **27/171 Vikram Vihar, Lajpat Nagar-4, Near Moolchand Metro Station, New Delhi-110024**

PATIENT NAME (BLOCK LETTERS) : DILIP KUMAR SHARMA **AGE/SEX :** 34/M

IP No :..... **UHID No :**..... **Mobile No of Patient :** 9953869484

Date of Admission : 7-6-23 **Time of Admission :** 11:00

Date of Discharge : 7-6-23 **Time of Discharge :**.....

Address of the Patien: H.NO-6542, Sanjay Colony, Sec-33, FBD, HR.

NAME OF THE ATTENDANT :..... **Relationship with the Patient :**.....

Mobile No. of Attendant :..... **Address:**.....

Declaration regarding Insurance Policy (Strike off the option which is not applicable)

(i) ***Declaration when patient has no insurance policy:***

- I declare that I do not have any insurance policy.

(ii) ***Declaration when patient has insurance policy:***

- I declare that I have following Insurance Policies

Policy No/TPA card No: 0402002822P104982910

Insurance Company: UNITED INDIA

2) Whether patient opted for Eligible Room Category under Policy:
Yes / No

3) In case, policyholder wishes to avail better facility:

Name of the Additional Facility/ Provision/ Procedure/ Treatment:
----------which costs Rs
:..... (In words:
.....) only.

On my own option, I wish to avail above better facility and I hereby agree to pay on my free will, after being explained in detail by the Hospital authority in my own and understandable language about the above mentioned Additional Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed PPN tariff. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed PPN tariff rates and balance amount will be borne by myself or patient only.

I have also been explained that when room service of a category better than eligible room rent is availed by the patient, not only the difference in room rent but also an equal proportion of all other charges associated with the treatment shall be borne by me.

Signature :.....
Name of the Patient/Patient's attendant:

Signature : **Ms. Zenab**
Name of the Hospital Representative & Hospital Seal :